America's Health
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September 8, 2020

Attention: Sergio Cavazos, Committee Clerk
Representative Eddie Lucio III, Chair
Insurance Committee
Texas House of Representatives

Email to: Sergio.Cavazos_HC@house.texas.gov

RE: AHIP Comments on House Insurance Committee Request for Information (Interim Charge 1)

Dear Chairman Lucio and Committee Members,

America's Health Insurance Plans (AHIP) appreciates the opportunity to share our national perspective and provide comments in response to the House Insurance Committee's Request for Information (RFI; August 11, 2020). Specifically, we would like to address Interim Charge 1 and the Committee's oversight of S.B. 1264, enacted by the 86th Legislature. As described in the RFI, the legislation prohibits balance billing (a.k.a., surprise medical billing), creates an arbitration system for certain out-of-network (OON) providers to settle balance bills, and directs the Texas Department of Insurance (TDI) to select a benchmarking database (capable of calculating the 80th percentile of providers' billed charges and the 50th percentile of rates paid to participating providers) for consideration in arbitration determinations.

AHIP remains concerned about the inclusion of billed charges in this arbitration determination process. On behalf of health insurance providers and the consumers we serve, we have been working across the states and with Congress to find solutions to alleviate the financial burdens imposed on patients by surprise medical bills, which affect at least one in five Americans annually. Approaches that require insurers to pay OON providers based on methodology that uses billed charges means that payment amounts would have no guardrails and no reasonable parameters and would allow providers to charge whatever fee they choose. A system based on billed charges typically leads to health care purchasers - employers, taxpayers and health insurance providers - paying far more than negotiated rates for care, which increases premiums for everyone.

The Texas Department of Insurance has selected FAIR Health as the benchmarking database for SB 1264's arbitration process. We understand that FAIR Health has benchmarking modules that include either billed charges or maximum allowed amounts for reimbursement of provider charges. TDI's Six-Month Preliminary Report on the implementation of SB 1264 shows that of the over 8,000 requests submitted for arbitration, those settled through arbitration have an average awarded amount much closer to the average billed charge.

AHIP believes reimbursement to OON providers should not be based on a methodology that uses billed charges. We support a benchmark approach which promotes affordable care, reasonable reimbursement

and market stability. AHIP believes reasonable reimbursement is based on a market rate or what the market is already paying for services (i.e., accepted rates, contracted rates, or government payment fee schedules). Billed charges are generally higher than the amount paid to providers under negotiated health plan contracts, or Medicare or Medicaid payment rates. A study using Texas-specific data from FAIR Health revealed average billed charges at up to 1283.9% of Medicare reimbursement rates.[1]

Benchmarking rates to market-based negotiations and/or Medicare payment amounts will help promote more affordable health care. Further, relying on such benchmark payment amounts would allow for local considerations and the costs of providing care by differing specialists to be part of the payment determination. Health plans negotiate different rates in different regions of the state based on unique cost considerations that underly the practice of medicine and provision of care in each area. Through these processes of good faith negotiations with health care providers, the factors that would otherwise be considered in an arbitration process are part of the negotiation.

As Congress continues to debate reasonable reimbursement criteria, we commend states across the country that are taking steps to protect their citizens from surprise medical bills. We encourage policymakers to ensure Americans are not only protected from surprise medical bills but also premium increases that would result from using an OON benchmark that allows providers to charge whatever they want. We stand ready to lend our expertise and efforts to ensure access to affordable high-quality care for all Americans.

Thank you for your consideration. We appreciate the Committee's commitment in focusing on such an important topic. Please reach out with any questions or concerns related to our comments.

Sincerely,

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cc: House Insurance Committee Members
Billy Phenix

America's Health Insurance Plans (AHIP) *is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers. Visit www.ahip.org for more information.*

[1] Charges Billed by Out-of-Network Providers: Implications for Affordability. Page 13. America's Health Insurance Plans. September 2015. Available at https://www.ahip.org/wp-content/uploads/2015/09/OON_Report_11.3.16.pdf.